LOUSIANA PATIENT'S COMPENSATION FUND

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I am hereby authorizing and consenting to the disclosure of information by the Louisiana Patient's Compensation Fund relative to medical malpractice records and enrollment records as a participant in the Fund, which pertains to my professional qualifications, professional liability insurance coverage and malpractice claims history to the entity named below.

Named Entity: _____

Contact Person: _____

Address: _____

Phone/Fax: _____

Date or Request: _____

Health Care Provider Printed Name: _____

Health Care Provider Signature: _____

Date: _____